AMENDED IN SENATE AUGUST 20, 2010

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CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 2244

Introduced by Assembly Member Feuer

February 18, 2010

An act to *amend Sections 1357.06 and 1357.51 of, and to* add Article 11.7 (commencing with Section 1399.825) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to *amend Sections 10198.7 and 10708 of, and to* add Chapter 9.7 (commencing with Section 10950) to Part 2 of Division 2 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2244, as amended, Feuer. Health care coverage.

Existing law, the federal Patient Protection and Affordable Care Act, on and after January 1, 2014, requires a health insurance issuer offering health insurance coverage in the individual or group market to accept every employer and individual in the state that applies for that coverage, as specified, and allows premiums for coverage in the individual or small group market to vary only by rating area, age, tobacco use, and whether the coverage is for an individual or family, as specified. The act also prohibits a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition for children with respect to plan years beginning on or after September 23,

2010, and for adults with respect to plan years beginning on or after January 1, 2014.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes a health care service plan or health insurer to exclude an applicant from coverage for a specified time for preexisting conditions. A willful violation of provisions governing health care service plans is a crime.

This bill would ~~require all health care service plans and health insurers that offer individual health care coverage to offer that coverage, by specified dates, to any child or adult seeking coverage. The bill would also~~ prohibit~~, by specified dates~~, the exclusion or limitation of coverage *for children* due to any preexisting condition, *except as specified*. The bill would further ~~establish and require the implementation of certain rating bands with respect to plan contracts or health insurance policies that provide coverage to children, as specified,~~ *require plans and insurers offering coverage in the individual market to offer coverage for a child subject to specified requirements. The bill would prescribe its limits on the rates that may be imposed for coverage of a child depending on, among other things, whether the child applies for coverage during an open enrollment period, as defined, or is a late enrollee, as defined,* and would, effective January 1, 2014, require plans and insurers to apply standard risk rates to ~~both adult and~~ child coverage, *except as specified. The bill would prohibit a plan or carrier that does not or ceases to write new plan contracts or policies for children from offering new individual plan contracts or policies in this state for 5 years.* The bill would authorize the Department of Managed Health Care and the Department of Insurance to ~~adopt emergency regulations~~ *issue guidance* for purposes of implementing these provisions.

By imposing new requirements on health care service plans, the willful violation of which would be a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1357.06 of the Health and Safety Code is amended to read:

1357.06. (a) *(1)* Preexisting condition provisions of a plan contract shall not exclude coverage for a period beyond six months following the individual's effective date of coverage and may only relate to conditions for which medical advice, diagnosis, care, or treatment, including prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(2) Notwithstanding paragraph (1), a plan contract offered to a small employer shall not impose any preexisting condition provision upon any child under 19 years of age.

(b) A plan that does not utilize a preexisting condition provision may impose a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period no premiums shall be charged to the enrollee or the subscriber.

(c) In determining whether a preexisting condition provision or a waiting or affiliation period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage with the succeeding plan contract within the applicable enrollment period. A plan shall also credit any time an eligible employee must wait before enrolling in the plan, including any affiliation or employer-imposed waiting or affiliation period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any

waiting or affiliation period, and applies for coverage under the succeeding plan contract within the applicable enrollment period.

(d) In addition to the preexisting condition exclusions authorized by subdivision (a) and the waiting or affiliation period authorized by subdivision (b), health plans providing coverage to a guaranteed association may impose on employers or individuals purchasing coverage who would not be eligible for guaranteed coverage if they were not purchasing through the association a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, no premiums shall be charged to the enrollee or the subscriber.

(e) An individual's period of creditable coverage shall be certified pursuant to subdivision (e) of Section 2701 of Title XXVII of the federal Public Health Services Act(42 U.S.C. Sec. 300gg(e)).

(f) A health care service plan issuing group coverage may not impose a preexisting condition exclusion to ~~any of the following: (1) To a newborn individual, who, as of the last day of the 30-day period beginning with the date of birth, has applied for coverage through the employer-sponsored plan. (2) To a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning with the date of adoption or placement for adoption, is covered under creditable coverage and applies for coverage through the employer-sponsored plan. This provision shall not apply if, for 63 continuous days, the child is not covered under any creditable coverage. (3) To~~ a condition relating to benefits for pregnancy or maternity care.

SEC. 2. Section 1357.51 of the Health and Safety Code is amended to read:

1357.51. (a) No plan contract that covers three or more enrollees shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage. Preexisting condition provisions contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) No plan contract that covers one or two individuals shall exclude coverage on the basis of a preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor shall the plan limit or exclude coverage for a specific enrollee by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause pursuant to this article. Preexisting condition provisions contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(c) (1) Notwithstanding subdivision (a), a plan contract for group coverage shall not impose any preexisting condition provision upon any child under 19 years of age.

(2) Notwithstanding subdivision (b), a plan contract for individual coverage that is not a grandfathered health within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) shall not impose any preexisting condition provision upon any child under 19 years of age.

~~(c)~~

(d) A plan that does not utilize a preexisting condition provision may impose a waiting or affiliation period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, the plan is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.

~~(d)~~

(e) A plan that does not utilize a preexisting condition provision in plan contracts that cover one or two individuals may impose a contract provision excluding coverage for waivered conditions. No plan may exclude coverage on the basis of a waivered condition for a period greater than 12 months following the individual's effective date of coverage. A waivered condition provision contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

~~(e)~~

(f) In determining whether a preexisting condition provision, a waivered condition provision, or a waiting or affiliation period applies to any enrollee, a plan shall credit the time the enrollee was covered under creditable coverage, provided that the enrollee becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period. A plan shall also credit any time that an eligible employee must wait before enrolling in the plan, including any postenrollment or employer-imposed waiting or affiliation period.

However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan contract within the applicable enrollment period.

~~(f)~~

(g) No plan shall exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No plan shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

~~(g)~~

(h) A health care service plan issuing group coverage may not impose a preexisting condition exclusion upon ~~the following:~~

~~(1) A newborn individual, who, as of the last day of the 30-day period beginning with the date of birth, has applied for coverage through the employer-sponsored plan.~~

~~(2) A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning with the date of adoption or placement for adoption, is covered under creditable coverage and applies for coverage through the employer-sponsored plan. This provision shall not apply if, for 63 continuous days, the child is not covered under any creditable coverage.~~

~~(3) A~~ *a* condition relating to benefits for pregnancy or maternity care.

~~(h)~~

(i) An individual's period of creditable coverage shall be certified pursuant to subsection (e) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(e)).

~~SECTION 1.~~

SEC. 3. Article 11.7 (commencing with Section 1399.825) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 11.7. Individual Access to Health Care Coverage

1399.825. As used in this article:

(a) ~~(1)~~ "Child" means any individual under 19 years of age.

~~(2) "Responsible party for a child" means an adult having custody of a child with the right to make medical decisions for, and with the responsibility for the financial needs of, the child.~~

~~(b) "Individual" means any individual 19 years of age or older.~~

~~(c) "In-force business" means an existing health care service plan contract issued by a health care service plan to an individual.~~

~~(d) "New business" means a health care service plan contract issued to an individual that is not the plan's in-force business.~~

~~(e) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the enrollee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.~~

~~(f) "Rating period" means the period for which premium rates established by a plan are in effect and shall be no less than 12 months.~~

~~(g) "Risk-adjusted individual risk rate" means the rate determined for an eligible individual or child in a particular risk category after applying the risk adjustment factor.~~

~~(h) "Risk adjustment factor" means the percentage adjustment to be applied equally to each standard risk rate for a particular child, based upon any expected deviations from standard cost of services. Between January 1, 2011, and December 31, 2011,~~

~~inclusive, this factor may not be more than 120 percent or less than 80 percent. Between January 1, 2012, and December 31, 2013, inclusive, this factor may not be more than 110 percent or less than 90 percent. Effective January 1, 2014, the standard risk rate shall apply to all contracts sold to individuals or for children.~~

~~(i) "Risk category" means the following characteristics of an eligible child: age, geographic region, and family composition of the individual, plus the health care service plan selected by the individual.~~

~~(1) Until January 1, 2014, no more than the following age categories may be used in determining premium rates:~~

~~(A) Under age 1.~~

~~(B) Age 1–19.~~

~~(2) The rate shall not vary by more than 2 to 1 for children.~~

~~(3) Individual health care service plans shall base rates for individuals and children using no more than the following family size categories:~~

~~(A) Single.~~

~~(B) More than one child and no adults.~~

~~(C) Married couple or registered domestic partners.~~

~~(D) One adult and one child.~~

~~(E) One adult and children.~~

~~(F) Married couple and child or children, or registered domestic partners and child or children.~~

~~(4) In determining rates for individuals and children, a plan that operates statewide shall use the geographic regions specified in Section 1357.~~

~~(j) Nothing in this section shall be construed to require a plan to establish a new service area or to offer health coverage on a statewide basis, outside of the plan's existing service area.~~

~~1399.826. (a) (1) Effective January 1, 2011, every health care service plan offering plan contracts for children shall offer coverage to the responsible party for any child that seeks coverage.~~

~~(2) Effective January 1, 2014, every health care service plan offering plan contracts to individuals shall offer coverage to any individual who seeks coverage.~~

~~(b) (1) Effective January 1, 2011, notwithstanding any other provision of state law or regulation, every health care service plan offering contracts for children shall not exclude or limit coverage due to any preexisting condition.~~

~~(2) Effective January 1, 2014, notwithstanding any other provision of state law or regulation, every health care service plan offering contracts for individuals shall not exclude or limit coverage due to any preexisting condition.~~

~~(c) This article shall not apply to coverage to which an employer makes any contribution.~~

~~(d) Every health care service plan offering plan contracts to individuals shall, in addition to complying with the provisions of this chapter and the rules adopted thereunder, comply with the provisions of this article.~~

(b) "Individual grandfathered plan coverage" means health care coverage in which an individual was enrolled on March 23, 2010, consistent with Section 1251 of PPACA and any rules or regulations adopted pursuant to that law.

(c) "Initial open enrollment period" means the open enrollment period beginning on January 1, 2011, and ending 60 days thereafter.

(d) "Late enrollee" means a child without coverage who did not enroll in a health care service plan contract during an open enrollment period because of any of the following:

(1) The child lost dependent coverage due to termination or change in employment status of the child or the person through whom the child was covered; cessation of an employer's contribution toward an employee or dependent's coverage; death of the person through whom the child was covered as a dependent; legal separation; divorce; loss of coverage under the Healthy Families Program, the Access for Infants and Mothers Program, or the Medi-Cal program; or adoption of the child.

(2) The child became a resident of California during a month that was not the child's birth month.

(3) The child is born as a resident of California and did not enroll in the month of birth.

(4) The child is mandated to be covered pursuant to a valid state or federal court order.

(e) "Open enrollment period" means the annual open enrollment period, subsequent to the initial open enrollment period, applicable to each individual child that is the month of the child's birth date.

(f) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public

Law 111-152), and any subsequent rules or regulations issued pursuant to that law.

(g) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment of the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

(h) "Responsible party for a child" means an adult having custody of the child or with responsibility for the financial needs of the child, including the responsibility to provide health care coverage.

(i) "Standard risk rate" means the lowest rate that can be offered for a child with the same benefit plan, effective date, age, geographic region, and family status.

1399.826. (a) (1) During each open enrollment period, every health care service plan offering plan contracts in the individual market, other than individual grandfathered plan coverage, shall offer to the responsible party for a child coverage for the child that does not exclude or limit coverage due to any preexisting condition of the child.

(b) A health care service plan offering coverage in the individual market shall not reject an application for a health care service plan contract from a child or filed on behalf of a child by the responsible party during an open enrollment period or from a late enrollee during a period no longer than 63 days from the qualifying event listed in subdivision (d) of Section 1399.825.

(c) Except to the extent permitted by federal law, rules, regulations, or guidance issued by the relevant federal agency, a health care service plan shall not condition the issuance or offering of individual coverage on any of the following factors:

(1) Health status.

(2) Medical condition, including physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

(9) Any other health status-related factor as determined by department.

This subdivision shall not apply to a contract providing individual grandfathered plan coverage.

(d) When a responsible party for a child submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan contract shall become effective no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(e) A health care service plan offering coverage in the individual market shall not reject the request of a responsible party for a child to include that child as a dependent on an existing health care service plan contract that includes dependent coverage during an open enrollment period.

(f) Nothing in this article shall be construed to prohibit a health care service plan offering coverage in the individual market from establishing rules for eligibility for coverage and offering coverage pursuant to those rules for children and individuals based on factors otherwise authorized under federal and state law for health plan contracts in addition to those offered on a guaranteed issue basis during an open enrollment period to children or late enrollees pursuant to this article. However, a health care service plan, other than a plan providing individual grandfathered plan coverage, shall not impose a preexisting condition provision on coverage, including dependent coverage, offered to a child.

(g) Nothing in this article shall be construed to require a plan to establish a new service area or to offer health coverage on a statewide basis, outside of the plan's existing service area.

(h) Nothing in this article shall be construed to prevent a health care service plan from offering coverage to a family member of an enrollee in grandfathered health plan coverage consistent with Section 1251 of PPACA.

1399.827. This article shall not apply to health care service plan contracts for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement contracts, Medi-Cal contracts with the State Department of Health

Care Services, plan contracts offered under the Healthy Families Program, long-term care coverage, or specialized health care service plan contracts.

~~1399.828. (a) Upon the effective date of this article, a health care service plan shall fairly and affirmatively offer, market, and sell all of the plan's health care service plan contracts that are offered and sold to the responsible party for a child. Effective January 1, 2014, a health care service plan shall fairly and affirmatively offer, market, and sell all of the plan's health care service plan contracts that are sold to individuals.~~

~~(b) Effective January 1, 2011, a health care service plan shall not reject an application from the responsible party for a child for a health care service plan contract. Effective January 1, 2014, a health care service plan shall not reject an application from an individual for a health care service plan contract.~~

1399.828. (a) Upon the effective date of this article, a health care service plan shall fairly and affirmatively offer, market, and sell all of the plan's health care service plan contracts that are offered and sold to a child or the responsible party for a child in each service area in which the plan provides or arranges for the provision of health care services during any open enrollment period, to late enrollees, and during any other period in which state or federal law, rules, regulations, or guidance expressly provide that a health care service plan shall not condition offer or acceptance of coverage on any preexisting condition.

~~(c)~~

(b) No health care service plan or solicitor shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct ~~an individual~~ *a child* or responsible party for a child to refrain from filing an application for coverage with a plan because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the plan's approved service area, of the ~~individual or~~ child.

(2) Encourage or direct ~~individuals or children~~ *a child or responsible party for a child* to seek coverage from another plan because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the plan's approved service area, of the individual or child.

~~(d)~~

(c) A health care service plan shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract to be varied because of the health status, claims experience, industry, occupation, or geographic location of the ~~individual or~~ child. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the ~~individual or~~ child.

~~(e) Effective January 1, 2011, a health care service plan contract that covers a child shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related factors:~~

~~(1) Health status.~~

~~(2) Medical condition, including physical and mental illnesses.~~

~~(3) Claims experience.~~

~~(4) Receipt of health care.~~

~~(5) Medical history.~~

~~(6) Genetic information.~~

~~(7) Evidence of insurability, including conditions arising out of acts of domestic violence.~~

~~(8) Disability.~~

~~(9) Any other health status-related factor determined appropriate by department.~~

~~1399.829. (a) After an individual or the responsible party for a child submits a completed application form for a plan contract, the health care service plan shall, within 30 days, notify the individual or responsible party for a child of actual premium charges for that plan contract established in accordance with Section 1399.836. The individual or responsible party for a child shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.~~

~~(b) When an individual or the responsible party for a child submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan contract shall become effective no later than the first day of~~

~~the following month. If that payment is delivered or postmarked after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.~~

~~(c) During the first 60 days after the effective date of the plan contract, the individual or responsible party for a child shall have the option of changing coverage to a different plan contract offered by the same health care service plan. If an individual or the responsible party for a child notifies the plan of the change within the first 15 days of a month, coverage under the new plan contract shall become effective no later than the first day of the following month. If an individual or the responsible party for a child notifies the plan of the change after the 15th day of a month, coverage under the new plan contract shall become effective no later than the first day of the second month following notification.~~

~~1399.830. (a) Effective January 1, 2011, a health care service plan may not exclude any child who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that child. No health care service plan contract may limit or exclude coverage for a child by type of illness, treatment, medical condition, or accident.~~

~~(b) Effective January 1, 2014, a health care service plan may not exclude any individual who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that individual. No health care service plan contract may limit or exclude coverage for a child by type of illness, treatment, medical condition, or accident.~~

1399.829. (a) A health care service plan may use the following characteristics of an eligible child for purposes of establishing the rate of the plan contract for that child, where consistent with federal regulations under PPACA: age, geographic region, and family composition, plus the health care service plan contract selected by the child or the responsible party for the child.

(b) From the effective date of this article to December 31, 2013, inclusive, rates for a child applying for coverage shall be subject to the following limitations:

(1) During any open enrollment period or for late enrollees, the rate for any child due to health status shall not be more than two times the standard risk rate for a child.

(2) The rate for a child shall be subject to a 20-percent surcharge above the highest allowable rate on a child applying for coverage who is not a late enrollee and who failed to maintain coverage with any health care service plan or health insurer for the 90-day period prior to the date of the child's application. The surcharge shall apply for the 12-month period following the effective date of the child's coverage.

(3) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a health care service plan may rate a child based on health status during any period other than an open enrollment period if the child is not a late enrollee.

(4) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a health care service plan may condition an offer or acceptance of coverage on any preexisting condition or other health status-related factor for a period other than an open enrollment period and for a child who is not a late enrollee.

(c) For any individual health care service plan contract issued, sold, or renewed prior to December 31, 2013, the health plan shall provide to a child or responsible party for a child a notice that states the following:

"Please consider your options carefully before failing to maintain or renew coverage for a child for whom you are responsible. If you attempt to obtain new individual coverage for that child, the premium for the same coverage may be higher than the premium you pay now."

(d) A child who applied for coverage between September 23, 2010, and the end of the initial open enrollment period shall be deemed to have maintained coverage during that period.

(e) Effective January 1, 2014, except for individual grandfathered health plan coverage, the rate for any child shall be identical to the standard risk rate.

(f) Health care service plans may require documentation from applicants relating to their coverage history.

1399.832. No health care service plan shall be required to offer a health care service plan contract or accept applications for the contract pursuant to this article in the case of any of the following:

(a) To an individual or child, if the individual or child who is

(a) To a child, if the child who is to be covered by the plan contract does not work or reside within the plan's approved service areas.

(b) (1) Within a specific service area or portion of a service area, if the plan reasonably anticipates and demonstrates to the satisfaction of the director that it will not have sufficient health care delivery resources to ensure that health care services will be available and accessible to the ~~individual or~~ child because of its obligations to existing enrollees.

(2) A health care service plan that cannot offer a health care service plan contract to individuals or children because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a contract in the area in which the plan is not offering coverage to individuals to new employer groups until the plan notifies the director that it has the ability to deliver services to individuals, and certifies to the director that from the date of the notice it will enroll all individuals requesting coverage in that area from the plan.

(3) Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity has become impaired.

1399.833. The director may require a health care service plan to discontinue the offering of contracts or acceptance of applications from any individual or child *or responsible party for a child* upon a determination by the director that the plan does not have sufficient financial viability or organizational and administrative capacity to ensure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375.1), and the rules adopted under those provisions.

~~1399.834. All health care service plan contracts offered to a child or individual shall be renewable at the option of the enrollee or responsible party for a child except:~~

~~(a) For nonpayment of the required premiums by the enrollee or responsible party for a child.~~

~~(b) For fraud or misrepresentation by the individuals or their representatives.~~

~~(c) When the health care service plan ceases to provide or arrange for the provision of health care services for new individual health care service plan contracts in this state; provided, however, that the following conditions are satisfied:~~

~~(1) Notice of the decision to cease new or existing individual health care service plan contracts in this state is provided to the director and to the contractholder at least 360 days prior to the discontinuation of the coverage.~~

~~(2) Individual health care service plan contracts subject to this article shall not be canceled for 360 days after the date of the notice required under paragraph (1) and for that business of a plan which remains in force, any plan that ceases to offer for sale new individual health care service plan contracts shall continue to be governed by this article with respect to business conducted under this article.~~

~~(3) Except as authorized under Section 1399.833, a plan that ceases to write new individual business in this state after the effective date of this article shall be prohibited from offering for sale new individual health care service plan contracts in this state for a period of five years from the date of notice to the director.~~

~~(d) When the health care service plan withdraws a health care service plan contract from the individual market; provided, the plan notifies all affected contractholders and the director at least 180 days prior to the discontinuation of those contracts, and the plan makes available to the individual all plan contracts that it makes available to new individual business; and provided, that the premium for the new plan contract complies with the renewal increase requirements set forth in Section 1399.836.~~

~~1399.836. Effective January 1, 2011, premiums for contracts offered or delivered by health care service plans on or after the effective date of this article for children shall be subject to the following requirements:~~

~~(a) The premium for new business shall be determined for an eligible child in a particular risk category after applying a risk adjustment factor to the plan's standard risk rates. Between January 1, 2011, and December 31, 2011, inclusive, the risk adjusted risk rate may not be more than 120 percent or less than 80 percent of the plan's applicable standard risk rate. Between January 1, 2012,~~

~~and December 31, 2013, inclusive, this factor may not be more than 110 percent or less than 90 percent. The standard risk rates applied to a child for new business shall be in effect for no less than 12 months.~~

~~(b) (1) The premium for in force business shall be determined for an eligible child in a particular risk category after applying a risk adjustment factor to the plan's standard individual risk rates. Between January 1, 2011, and December 31, 2011, inclusive, the risk adjusted individual risk rates may not be more than 120 percent or less than 80 percent of the plan's applicable standard risk rate. Between January 1, 2012, and December 31, 2013, inclusive, this factor may not be more than 110 percent or less than 90 percent. The factor effective January 1, 2011, shall apply to in force business at the earlier of either the time of renewal or January 1, 2012. The risk adjustment factor applied to a child may not increase by more than 10 percentage points from the risk adjustment factor applied in the prior rating period. The risk adjustment factor for a child may not be modified more frequently than once every 12 months.~~

~~(2) The standard risk rates shall be in effect for no less than 12 months.~~

~~(3) For a contract that a plan has discontinued offering, the risk adjustment factor applied to the standard risk rates for the first rating period of the new contract that the responsible party for the child elects to purchase shall be no greater than the risk adjustment factor applied in the prior rating period to the discontinued contract. However, between January 1, 2011, and December 31, 2011, inclusive, the risk adjusted individual risk rate may not be more than 120 percent or less than 80 percent of the plan's applicable standard risk rate. Between January 1, 2012, and December 31, 2013, inclusive, this factor may not be more than 110 percent or less than 90 percent. The factor effective January 1, 2011, shall apply to in force business at the earlier of either the time of renewal or January 1, 2012. The risk adjustment factor for a child may not be modified more frequently than once every 12 months.~~

~~1399.837. Health care service plans shall apply standard risk rates consistently with respect to all children.~~

~~1399.838. In connection with the offering for sale of any plan contract for children, each plan shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:~~

~~(a) The extent to which premium rates for a specific child are established or adjusted in part based upon the actual or expected variation in service costs or actual or expected variation in health condition of the child.~~

~~(b) The provisions concerning the plan's right to change premium rates and the factors, other than provision of services experience, that affect changes in premium rates.~~

~~(c) Provisions relating to the guaranteed issue and renewal of contracts.~~

~~(d) Provisions relating to the child's right to apply for any contract written, issued, or administered by the plan at the time of application for a new health care service plan contract, or at the time of renewal of a health care service plan contract.~~

~~(e) The availability, upon request, of a listing of all the plan's contracts and benefit plan designs offered for children, including the rates for each contract.~~

~~(f) At the time it offers a contract to the responsible party for a child, each plan shall provide the responsible party with a statement of all of its plan contracts offered to children, including the rates for each plan contract, in the service area in which the individuals who are to be covered by the plan contract reside. For purposes of this subdivision, plans that are affiliated plans or that are eligible to file a consolidated income tax return shall be treated as one health plan.~~

~~(g) Each health care service plan shall do all of the following:~~

~~(1) Prepare a brochure that summarizes all of its plan contracts offered to children and to make this summary available to any responsible party for a child and to solicitors upon request. The summary shall include for each contract information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, standard risk rates, and a telephone number that can be called for more detailed benefit information. Plans are required to keep the information contained in the brochure accurate and up to date and, upon updating the brochure, send copies to solicitors and solicitor firms with whom the plan contracts to solicit enrollments or subscriptions.~~

~~(2) For each contract, prepare a more detailed evidence of coverage and make it available to responsible parties, solicitors,~~

~~and solicitor firms upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making contract selections.~~

~~(3) Provide to responsible parties and solicitors, upon request, for any given child the standard risk rates. When requesting this information, responsible parties, solicitors, and solicitor firms shall provide the plan with the information the plan needs to determine the child's risk adjusted risk rate.~~

~~(4) Provide copies of the current summary brochure to all solicitors and solicitor firms contracting with the plan to solicit enrollments or subscriptions from responsible parties for children.~~

~~For purposes of this subdivision, plans that are affiliated plans or that are eligible to file a consolidated income tax return shall be treated as one health plan.~~

~~(h) Every solicitor or solicitor firm contracting with one or more plans to solicit enrollments or subscriptions from responsible parties for children shall do all of the following:~~

~~(1) When providing information on contracts to a responsible party for a child or children but making no specific recommendations on particular plan contracts:~~

~~(A) Advise the responsible party of the plan's obligation to sell to any responsible party any plan contract it offers for children and provide them, upon request, with the actual rates that would be charged for that child for a given contract.~~

~~(B) Notify the responsible party that the solicitor or solicitor firm will procure rate and benefit information for the responsible party for the child on any plan contract offered by a plan whose contract the solicitor sells.~~

~~(C) Notify the responsible party that upon request the solicitor or solicitor firm will provide the responsible party with the summary brochure required under this paragraph for any plan contract offered by a plan with whom the solicitor or solicitor firm has contracted to solicit enrollments or subscriptions.~~

~~(2) When recommending a particular benefit plan design or designs, advise the responsible party that, upon request, the agent will provide the responsible party with the brochure required by paragraph (1) containing the benefit plan design or designs being recommended by the agent or broker.~~

~~(3) Prior to filing an application for a responsible party for a child for a particular contract:~~

~~(A) For each of the plan contracts offered by the plan whose contract the solicitor or solicitor firm is offering, provide the responsible party with the benefit summary required in paragraph (1) and the standard risk rates for that particular child.~~

~~(B) Notify the responsible party that, upon request, the solicitor or solicitor firm will provide the responsible party with an evidence of coverage brochure for each contract the plan offers.~~

~~(C) Notify the responsible party for a child that, from January 1, 2011, to December 31, 2011, inclusive, actual rates may be 20 percent higher or lower than the standard risk rates, and from January 1, 2012, to December 31, 2013, inclusive, actual rates may be 10 percent higher or lower than the standard risk rates, depending on how the plan assesses the risk of the child.~~

~~(D) Notify the responsible party that, upon request, the solicitor or solicitor firm will submit information to the plan to ascertain the child's risk adjusted risk rate for any contract the plan offers.~~

~~(E) Obtain a signed statement from the responsible party acknowledging that the responsible party has received the disclosures required by this section.~~

~~1399.839. (a) At least 30 business days prior to renewing or amending a plan contract subject to this article that will be in force on the operative date of this article, a plan shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with subdivision (i) of Section 1399.825 and Section 1399.836. The certified statement shall set forth the standard risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be renewed or amended. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract is not in compliance with the requirements of this chapter.~~

~~(b) At least 30 business days prior to offering a plan contract subject to this article, all plans shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with subdivision (i) of Section 1399.825 and Section 1399.836. The~~

~~certified statement shall set forth the standard risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be offered. Plans that will be offering to a responsible party for a child contracts approved by the director prior to the effective date of this article shall file a notice of material modification in accordance with this subdivision. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract is not in compliance with the requirements of this chapter.~~

~~(c) Prior to making any changes in the risk categories, risk adjustment factors, or standard risk rates filed with the director pursuant to subdivision (a) or (b), the plan shall file, as an amendment, a statement setting forth the changes and certifying that the plan is in compliance with subdivision (i) of Section 1399.825 and Section 1399.836. A plan may commence offering plan contracts utilizing the changed risk categories set forth in the certified statement on the 45th day from the date of the filing, or at an earlier time determined by the director, unless the director disapproves the amendment by written notice, stating the reasons therefor. If only the standard risk rate is being changed, and not the risk categories or risk adjustment factors, a plan may commence offering plan contracts utilizing the changed standard risk rate upon the 31st day after filing the certified statement unless the director disapproves the amendment by written notice.~~

~~(d) Periodic changes to the standard risk rate that a plan proposes to implement over the course of up to 12 consecutive months may be filed in conjunction with the certified statement filed under subdivision (a), (b), or (c).~~

~~(e) Each plan shall maintain at its principal place of business all of the information required to be filed with the director pursuant to this section.~~

~~(f) Each plan shall make available to the director, on request, the risk adjustment factor used in determining the rate for any particular child.~~

~~(g) Nothing in this section shall be construed to limit the director's authority to enforce the rating practices set forth in this article.~~

~~1399.840. The director may issue regulations that are necessary to carry out the purposes of this article. Prior to the public comment period required by regulations under the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the director shall provide the Insurance Commissioner with a copy of the proposed regulations. The Insurance Commissioner shall have 30 days to notify the director in writing of any comments on the regulations. The Insurance Commissioner's comments shall be included in the public notice issued on the regulations. Any rules and regulations adopted pursuant to this article may be adopted as emergency regulations in accordance with the Administrative Procedure Act. Until December 31, 2015, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Any regulations adopted prior to December 31, 2015, in order to remain in effect after December 31, 2016, shall be readopted as nonemergency regulations in accordance with the Administrative Procedure Act prior to December 31, 2016.~~

1399.834. (a) All health care service plan contracts offered to a child or on behalf of a child to a responsible party for a child shall conform to the requirements of Sections 1366.3, 1365, and 1373.6 and shall be renewable at the option of the enrollee or responsible party for a child on behalf of the enrollee except as permitted to be canceled, rescinded, or not renewed pursuant to Section 1365.

(b) Any plan that ceases to offer for sale new individual health care service plan contracts pursuant to Section 1365 shall continue to be governed by this article with respect to business conducted under this article.

(c) Except as authorized under Section 1399.833, a plan that, as of the effective date of this article, does not write new health care service plan contracts for children in this state or that, after the effective date of this article, ceases to write new health care service plan contracts for children in this state shall be prohibited from offering for sale new individual health care service plan contracts in this state for a period of five years from the date of notice to the director.

1399.835. On or before July 1, 2011, the director may issue guidance to health plans regarding compliance with this article

and that guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The guidance shall only be effective until the director and the Insurance Commissioner adopt joint regulations pursuant to the Administrative Procedure Act.

SEC. 4. Section 10198.7 of the Insurance Code is amended to read:

10198.7. (a) No health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident except for satisfaction of a preexisting clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) No health benefit plan that covers one or two individuals and that is issued, renewed, or written by any insurer, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall exclude coverage on the basis of a preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(c) (1) Notwithstanding subdivision (a), a health benefit plan for group coverage shall not impose any preexisting condition provision upon any child under 19 years of age.

(2) Notwithstanding subdivision (b), a health benefit plan for individual coverage that is a grandfathered plan within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) shall not impose any preexisting condition provision upon any child under 19 years of age.

~~(c)~~

(d) A carrier that does not utilize a preexisting condition provision may impose a waiting or affiliation period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, the carrier is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.

~~(d)~~

(e) A carrier that does not utilize a preexisting condition provision in health plans that cover one or two individuals may impose a contract provision excluding coverage for waivered conditions. No carrier may exclude coverage on the basis of a waivered condition for a period greater than 12 months following the individual's effective date of coverage. A waivered condition provision contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

~~(e)~~

(f) In determining whether a preexisting condition provision, a waivered condition provision, or a waiting or affiliation period applies to any person, all health benefit plans shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding health benefit plan within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period. A health benefit plan shall also credit any time an eligible employee must wait before enrolling in the health benefit plan, including any affiliation or employer-imposed waiting period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated or, an employer's

contribution toward health coverage has terminated, a carrier shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period.

~~(f)~~

(g) No health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity may exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

~~(g)~~

(h) An individual's period of creditable coverage shall be certified pursuant to subdivision (e) of Section 2701 of Title XXVII of the federal Public Health Services Act, 42 U.S.C. Sec. 300gg(e).

~~(h)~~

(i) A group health benefit plan may not impose a preexisting condition exclusion to ~~any of the following:~~

~~(1) To a newborn individual, who, as of the last day of the 30-day period beginning with the date of birth, applied for coverage through the employer-sponsored plan.~~

~~(2) To a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning with the date of adoption or placement for adoption, is covered under creditable coverage and applies for coverage through the employer-sponsored plan. This provision shall not apply if, for 63 continuous days, the child is not covered under any creditable coverage.~~

~~(3) To~~ a condition relating to benefits for pregnancy or maternity care.

~~(i)~~

(j) Any entity providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this article concerning waiting periods, preexisting condition provisions, and late enrollees.

SEC. 5. Section 10708 of the Insurance Code is amended to read:

10708. (a) *(1)* Preexisting condition provisions of health benefit plans shall not exclude coverage for a period beyond six months following the individual's effective date of coverage and may only relate to conditions for which medical advice, diagnosis, care, or treatment, including the use of prescription medications, was recommended by or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(2) Notwithstanding paragraph (1), a health benefit plan offered to a small employer shall not impose any preexisting condition provision upon any child under 19 years of age.

(b) A carrier that does not utilize a preexisting condition provision may impose a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this chapter shall become effective. During the waiting or affiliation period, the carrier is not required to provide health care benefits and no premiums shall be charged to the subscriber or enrollee.

(c) In determining whether a preexisting condition provision or a waiting period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage with the succeeding health benefit plan contract within the applicable enrollment period. A plan shall also credit any time an eligible employee must wait before enrolling in the health benefit plan, including any postenrollment or employer-imposed waiting or affiliation period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through

employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding health benefit plan within the applicable enrollment period.

(d) Group health benefit plans may not impose a preexisting conditions exclusion to ~~the following: (1) To a newborn individual, who, as of the last day of the 30-day period beginning with the date of birth, applied for coverage through the employer-sponsored plan. (2) To a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning with the date of adoption or placement for adoption, is covered under creditable coverage and applies for coverage through the employer-sponsored plan. This provision shall not apply if, for 63 continuous days, the child is not covered under any creditable coverage. (3) To~~ a condition relating to benefits for pregnancy or maternity care.

(e) A carrier providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this section concerning preexisting condition provisions and waiting or affiliation periods.

(f) In addition to the preexisting condition exclusions authorized by subdivision (a) and the waiting or affiliation period authorized by subdivision (b), carriers providing coverage to a guaranteed association may impose on employers or individuals purchasing coverage who would not be eligible for guaranteed coverage if they were not purchasing through the association a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this chapter shall become effective. During the waiting or affiliation period, the carrier is not required to provide health care benefits and no premiums shall be charged to the insured.

~~SEC. 2.~~

SEC. 6. Chapter 9.7 (commencing with Section 10950) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 9.7. INDIVIDUAL ACCESS TO HEALTH INSURANCE

10950. As used in this chapter:

(a) ~~(1)~~ "Child" means any individual under 19 years of age.

~~(2) "Responsible party for a child" means an adult having custody of a child with the right to make medical decisions for, and with the responsibility for the financial needs of, the child.~~

~~(b) "Individual" means any individual 19 years of age or older.~~

~~(c) "In-force business" means an existing health benefit plan issued by a carrier to an individual.~~

~~(d) "New business" means a health benefit plan issued to an individual that is not the carrier's in-force business.~~

~~(e) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.~~

~~(f) "Rating period" means the period for which premium rates established by a carrier are in effect and shall be no less than 12 months.~~

~~(g) "Risk-adjusted individual risk rate" means the rate determined for an eligible individual or child in a particular risk category after applying the risk adjustment factor.~~

~~(h) "Risk adjustment factor" means the percentage adjustment to be applied equally to each standard risk rate for a particular child, based upon any expected deviations from standard cost of services. Between January 1, 2011, and December 31, 2011, inclusive, this factor may not be more than 120 percent or less than 80 percent. Between January 1, 2012, and December 31, 2013, inclusive, this factor may not be more than 110 percent or less than 90 percent. Effective January 1, 2014, the standard risk rate shall apply to all policies sold to individuals or for children.~~

~~(i) "Risk category" means the following characteristics of an eligible child: age, geographic region, and family composition of the individual, plus the health benefit plan selected by the individual.~~

~~(1) Until January 1, 2014, no more than the following age categories may be used in determining premium rates:~~

~~(A) Under age 1.~~

~~(B) Age 1 to 19.~~

~~(2) The rate shall not vary by more than 2 to 1 for children.~~

~~(3) Carriers shall base rates for individuals and children using no more than the following family size categories:~~

~~(A) Single.~~
~~(B) More than one child and no adults.~~
~~(C) Married couple or registered domestic partners.~~
~~(D) One adult and one child.~~
~~(E) One adult and children.~~
~~(F) Married couple and child or children, or registered domestic partners and child or children.~~
~~(4) In determining rates for individuals and children, a carrier that operates statewide shall use the geographic regions specified in Section 10700.~~
~~(j) Nothing in this section shall be construed to require a carrier to establish a new service area or to offer health coverage on a statewide basis, outside of the carrier's existing service area.~~
~~10951. (a) (1) Effective January 1, 2011, every carrier offering health benefit plans for children shall offer coverage to the responsible party for any child that seeks coverage.~~
~~(2) Effective January 1, 2014, every carrier offering health benefit plans to individuals shall offer coverage to any individual who seeks coverage.~~
~~(b) (1) Effective January 1, 2011, notwithstanding any other provision of state law or regulation, every carrier offering contracts for children shall not exclude or limit coverage due to any preexisting condition.~~
~~(2) Effective January 1, 2014, notwithstanding any other provision of state law or regulation, every carrier offering contracts for individuals shall not exclude or limit coverage due to any preexisting condition.~~
~~(c) This chapter shall not apply to coverage to which an employer makes any contribution.~~
~~(d) Every carrier offering health benefit plans to individuals shall, in addition to complying with the provisions of this part and the rules adopted thereunder, comply with the provisions of this chapter.~~
(b) "Individual grandfathered plan coverage" means health care coverage in which an individual was enrolled on March 23, 2010, consistent with Section 1251 of PPACA and any rules or regulations adopted pursuant to that law.
(c) "Initial open enrollment period" means the open enrollment period beginning on January 1, 2011, and ending 60 days thereafter.

(d) "Late enrollee" means a child without coverage who did not enroll in a health benefit plan during an open enrollment period because of any of the following:

(1) The child lost dependent coverage due to termination or change in employment status of the child or the person through whom the child was covered; cessation of an employer's contribution toward an employee or dependent's coverage; death of the person through whom the child was covered as a dependent; legal separation; divorce; loss of coverage under the Healthy Families Program, the Access for Infants and Mothers Program, or the Medi-Cal program; or adoption of the child.

(2) The child became a resident of California during a month that was not the child's birth month.

(3) The child is born as a resident of California and did not enroll in the month of birth.

(4) The child is mandated to be covered pursuant to a valid state or federal court order.

(e) "Open enrollment period" means the annual open enrollment period subsequent to the initial open enrollment period, applicable to each individual child that is the month of the child's birth date.

(f) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any subsequent rules or regulations issued pursuant to that law.

(g) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment of the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

(h) "Responsible party for a child" means an adult having custody of the child or with responsibility for the financial needs of the child, including the responsibility to provide health care coverage.

(i) "Standard risk rate" means the lowest rate that can be offered for a child with the same benefit plan, effective date, age, geographic region, and family status.

10951. (a) (1) During each open enrollment period, every carrier offering health benefit plans in the individual market, other

than individual grandfathered plan coverage, shall offer to the responsible party for a child coverage for the child that does not exclude or limit coverage due to any preexisting condition of the child.

(b) A carrier offering coverage in the individual market shall not reject an application for a health benefit plan from a child or filed on behalf of a child by the responsible party during an open enrollment period or from a late enrollee during a period no longer than 63 days from the qualifying event listed in subdivision (d) of Section 10950.

(c) Except to the extent permitted by federal law, rules, regulations, or guidance issued by the relevant federal agency, a carrier shall not condition the issuance or offering of individual coverage on any of the following factors:

(1) Health status.

(2) Medical condition, including physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

(9) Any other health status-related factor as determined by department.

This subdivision shall not apply to a health benefit plan providing individual grandfathered plan coverage.

(d) When a responsible party for a child submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the health benefit plan shall become effective no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(e) A carrier offering coverage in the individual market shall not reject the request of a responsible party for a child to include that child as a dependent on an existing health benefit plan that includes dependent coverage during an open enrollment period.

(f) Nothing in this chapter shall be construed to prohibit a carrier offering coverage in the individual market from establishing rules for eligibility for coverage and offering coverage pursuant to those rules for children and individuals based on factors otherwise authorized under federal and state law for health benefit plans in addition to those offered on a guaranteed issue basis during an open enrollment period to children or late enrollees pursuant to this chapter. However, a carrier, other than a carrier providing individual grandfathered plan coverage, shall not impose a preexisting condition provision on coverage, including dependent coverage, offered to a child.

(g) Nothing in this chapter shall be construed to require a carrier to establish a new service area or to offer health care coverage on a statewide basis, outside of the carrier's existing service area.

(h) Nothing in this chapter shall be construed to prevent a carrier from offering coverage to a family member of an enrollee in grandfathered health plan coverage consistent with Section 1251 of PPACA.

10952. This chapter shall not apply to health benefit plans for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement policies, Medi-Cal contracts with the State Department of Health Care Services, policies offered under the Healthy Families Program, long-term care coverage, or specialized health benefit plans.

~~10953. (a) Upon the effective date of this chapter, a carrier shall fairly and affirmatively offer, market, and sell all of the carrier's contracts that are offered and sold to the responsible party for a child. Effective January 1, 2014, a carrier shall fairly and affirmatively offer, market, and sell all of the carrier's contracts that are sold to individuals.~~

~~(b) Effective January 1, 2011, a carrier shall not reject an application from the responsible party for a child for a health benefit plan. Effective January 1, 2014, a carrier shall not reject an application from an individual for a health benefit plan.~~

10953. (a) Upon the effective date of this chapter, a carrier shall fairly and affirmatively offer, market, and sell all of the carrier's health benefit plans that are offered and sold to a child or the responsible party for a child in each service area in which the plan provides or arranges for health care coverage during any

open enrollment period, to late enrollees, and during any other period in which state or federal law, rules, regulations, or guidance expressly provide that a carrier shall not condition offer or acceptance of coverage on any preexisting condition.

~~(c)~~

(b) No carrier or solicitor shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct ~~an individual~~ *a child* or responsible party for a child to refrain from filing an application for coverage with a carrier because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the carrier's approved service area, of the ~~individual or~~ child.

(2) Encourage or direct ~~individuals or children~~ *a child or responsible party for a child* to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the carrier's approved service area, of the ~~individual or~~ child.

~~(d)~~

(c) A carrier shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the ~~individual or~~ child. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the ~~individual or~~ child.

~~(e) Effective January 1, 2011, a health benefit plan that covers a child shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the carrier based on any of the following health status-related factors:~~

~~(1) Health status.~~

~~(2) Medical condition, including physical and mental illnesses.~~

~~(3) Claims experience.~~

~~(4) Receipt of health care.~~

~~(5) Medical history.~~

~~(6) Genetic information.~~

~~(7) Evidence of insurability, including conditions arising out of acts of domestic violence.~~

~~(8) Disability.~~

~~(9) Any other health status-related factor determined appropriate by department.~~

~~(f) A carrier shall comply with the requirements of subdivision (c) of Section 10119.~~

~~(g) Effective January 1, 2014, this section shall apply to all individuals and children obtaining coverage with no contribution from an employer.~~

~~10954. (a) After an individual or the responsible party for a child submits a completed application form for a health benefit plan, the carrier shall, within 30 days, notify the individual or responsible party for a child of actual premium charges for that health benefit plan established in accordance with Section 10960. The individual or responsible party for a child shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.~~

~~(b) When an individual or the responsible party for a child submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the health benefit plan shall become effective no later than the first day of the following month. If that payment is delivered or postmarked after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.~~

~~(c) During the first 60 days after the effective date of the health benefit plan, the individual or responsible party for a child shall have the option of changing coverage to a different health benefit plan offered by the same carrier. If an individual or the responsible party for a child notifies the carrier of the change within the first 15 days of a month, coverage under the new health benefit plan shall become effective no later than the first day of the following month. If an individual or the responsible party for a child notifies the carrier of the change after the 15th day of a month, coverage under the new health benefit plan shall become effective no later than the first day of the second month following notification.~~

~~10955. (a) Effective January 1, 2011, a carrier may not exclude any child who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that child. No health benefit plan may limit or exclude coverage for a child by type of illness, treatment, medical condition, or accident.~~

~~(b) Effective January 1, 2014, a carrier may not exclude any individual who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that individual. No health benefit plan may limit or exclude coverage for a child by type of illness, treatment, medical condition, or accident.~~

10954. (a) A carrier may use the following characteristics of an eligible child for purposes of establishing the rate of the health benefit plan for that child, where consistent with federal regulations under PPACA: age, geographic region, and family composition, plus the health benefit plan selected by the child or the responsible party for a child.

(b) From the effective date of this chapter to December 31, 2013, inclusive, rates for a child applying for coverage shall be subject to the following limitations:

(1) During any open enrollment period or for late enrollees, the rate for any child due to health status shall not be more than two times the standard risk rate for a child.

(2) The rate for a child shall be subject to a 20-percent surcharge above the highest allowable rate on a child applying for coverage who is not a late enrollee and who failed to maintain coverage with any carrier or health care service plan for the 90-day period prior to the date of the child's application. The surcharge shall apply for the 12-month period following the effective date of the child's coverage.

(3) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a carrier may rate a child based on health status during any period other than an open enrollment period if the child is not a late enrollee.

(4) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a carrier may condition an offer or acceptance of coverage on any preexisting condition or other health status-related factor for a period other than an open enrollment period and for a child who is not a late enrollee.

(c) For any individual health benefit plan issued, sold, or renewed prior to December 31, 2013, the carrier shall provide to a child or responsible party for a child a notice that states the following:

"Please consider your options carefully before failing to maintain or renew coverage for a child for whom you are responsible. If you attempt to obtain new individual coverage for that child, the premium for the same coverage may be higher than the premium you pay now."

(d) A child who applied for coverage between September 23, 2010, and the end of the initial enrollment period shall be deemed to have maintained coverage during that period.

(e) Effective January 1, 2014, except for individual grandfathered health plan coverage, the rate for any child shall be identical to the standard risk rate.

(f) Carriers may require documentation from applicants relating to their coverage history.

10957. No carrier shall be required to offer a health benefit plan or accept applications for the contract pursuant to this chapter in the case of any of the following:

~~(a) To an individual or child, if the individual or child who is~~

(a) To a child, if the child who is to be covered by the health benefit plan does not work or reside within the carrier's approved service areas.

(b) (1) Within a specific service area or portion of a service area, if the carrier reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have sufficient health care delivery resources to ensure that health care services will be available and accessible to the ~~individual or~~ child because of its obligations to existing insureds.

(2) A carrier that cannot offer a health benefit plan to individuals or children because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a contract in the area in which the carrier is not offering coverage to individuals to new employer groups until the carrier notifies the commissioner that it has the ability to deliver services to individuals, and certifies to the commissioner that from the date

of the notice it will enroll all individuals requesting coverage in that area from the carrier.

(3) Nothing in this chapter shall be construed to limit the commissioner's authority to develop and implement a plan of rehabilitation for a carrier whose financial viability or organizational and administrative capacity has become impaired.

10958. The commissioner may require a carrier to discontinue the offering of contracts or acceptance of applications from any individual or child *or responsible party for a child* upon a determination by the commissioner that the carrier does not have sufficient financial viability or organizational and administrative capacity to ensure the delivery of health care services to its insureds. In determining whether the conditions of this section have been met, the commissioner shall consider, but not be limited to, the carrier's compliance with the requirements of this part and the rules adopted under those provisions.

~~10959. All health benefit plans offered to a child or individual shall be renewable at the option of the insured or responsible party for a child except:~~

~~(a) For nonpayment of the required premiums by the insured or responsible party for a child.~~

~~(b) For fraud or misrepresentation by the individuals or their representatives.~~

~~(c) When the carrier ceases to provide or arrange for the provision of health care services for new individual health benefit plans in this state; provided, however, that the following conditions are satisfied:~~

~~(1) Notice of the decision to cease new or existing individual health benefits plans in this state is provided to the commissioner and to the contractholder at least 360 days prior to the discontinuation of the coverage.~~

~~(2) Individual health benefit plans subject to this chapter shall not be canceled for 360 days after the date of the notice required under paragraph (1) and for that business of a carrier which remains in force, any carrier that ceases to offer for sale new individual health benefit plans shall continue to be governed by this chapter with respect to business conducted under this chapter.~~

~~(3) Except as authorized under Section 10958, a carrier that ceases to write new individual business in this state after the effective date of this chapter shall be prohibited from offering for~~

~~sale new individual health benefit plans in this state for a period of five years from the date of notice to the commissioner.~~

~~(d) When the carrier withdraws a health benefit plan from the individual market; provided, the carrier notifies all affected contractholders and the commissioner at least 180 days prior to the discontinuation of those contracts, and the carrier makes available to the individual all health benefit plans that it makes available to new individual business; and provided, that the premium for the new health benefit plan complies with the renewal increase requirements set forth in Section 10960.~~

~~10960. Effective January 1, 2011, premiums for contracts offered or delivered by carriers on or after the effective date of this chapter for children shall be subject to the following requirements:~~

~~(a) The premium for new business shall be determined for an eligible child in a particular risk category after applying a risk adjustment factor to the carrier's standard risk rates. Between January 1, 2011, and December 31, 2011, inclusive, the risk adjusted risk rate may not be more than 120 percent or less than 80 percent of the carrier's applicable standard risk rate. Between January 1, 2012, and December 31, 2013, inclusive, this factor may not be more than 110 percent or less than 90 percent. The standard risk rates applied to a child for new business shall be in effect for no less than 12 months.~~

~~(b) (1) The premium for in force business shall be determined for an eligible child in a particular risk category after applying a risk adjustment factor to the carrier's standard individual risk rates. Between January 1, 2011, and December 31, 2011, inclusive, the risk adjusted individual risk rates may not be more than 120 percent or less than 80 percent of the carrier's applicable standard risk rate. Between January 1, 2012, and December 31, 2013, inclusive, this factor may not be more than 110 percent or less than 90 percent. The factor effective January 1, 2011, shall apply to in force business at the earlier of either the time of renewal or January 1, 2012. The risk adjustment factor applied to a child may not increase by more than 10 percentage points from the risk adjustment factor applied in the prior rating period. The risk adjustment factor for a child may not be modified more frequently than once every 12 months.~~

~~(2) The standard risk rates shall be in effect for no less than 12 months.~~

~~(3) For a contract that a carrier has discontinued offering, the risk adjustment factor applied to the standard risk rates for the first rating period of the new contract that the responsible party for the child elects to purchase shall be no greater than the risk adjustment factor applied in the prior rating period to the discontinued contract. However, between January 1, 2011, and December 31, 2011, inclusive, the risk adjusted individual risk rate may not be more than 120 percent or less than 80 percent of the carrier's applicable standard risk rate. Between January 1, 2012, and December 31, 2013, inclusive, this factor may not be more than 110 percent or less than 90 percent. The factor effective January 1, 2011, shall apply to in force business at the earlier of either the time of renewal or January 1, 2012. The risk adjustment factor for a child may not be modified more frequently than once every 12 months.~~

~~10961. Carriers shall apply standard risk rates consistently with respect to all children.~~

~~10962. In connection with the offering for sale of any health benefit plan for children, each carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:~~

~~(a) The extent to which premium rates for a specific child are established or adjusted in part based upon the actual or expected variation in service costs or actual or expected variation in health condition of the child.~~

~~(b) The provisions concerning the carrier's right to change premium rates and the factors, other than provision of services experience, that affect changes in premium rates.~~

~~(c) Provisions relating to the guaranteed issue and renewal of contracts.~~

~~(d) Provisions relating to the child's right to apply for any contract written, issued, or administered by the carrier at the time of application for a new health benefit plan, or at the time of renewal of a health benefit plan.~~

~~(e) The availability, upon request, of a listing of all the plan's contracts and benefit plan designs offered for children, including the rates for each contract.~~

~~(f) At the time it offers a contract to the responsible party for a child, each carrier shall provide the responsible party with a~~

~~statement of all of its health benefit plans offered to children, including the rates for each health benefit plan, in the service area in which the individuals who are to be covered by the health benefit plan reside. For purposes of this subdivision, carriers that are affiliated carriers or that are eligible to file a consolidated income tax return shall be treated as one carrier.~~

~~(g) Each carrier shall do all of the following:~~

~~(1) Prepare a brochure that summarizes all of its health benefit plans offered to children and to make this summary available to any responsible party for a child and to solicitors upon request. The summary shall include for each contract information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, standard risk rates, and a telephone number that can be called for more detailed benefit information. Carriers are required to keep the information contained in the brochure accurate and up to date and, upon updating the brochure, send copies to solicitors and solicitor firms with whom the health benefit plans to solicit enrollments or subscriptions.~~

~~(2) For each contract, prepare a more detailed evidence of coverage and make it available to responsible parties, solicitors, and solicitor firms upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making contract selections.~~

~~(3) Provide to responsible parties and solicitors, upon request, for any given child the standard risk rates. When requesting this information, responsible parties, solicitors, and solicitor firms shall provide the carrier with the information the carrier needs to determine the child's risk adjusted risk rate.~~

~~(4) Provide copies of the current summary brochure to all solicitors and solicitor firms contracting with the carrier to solicit enrollments or subscriptions from responsible parties for children.~~

~~For purposes of this subdivision, carriers that are affiliated carriers or that are eligible to file a consolidated income tax return shall be treated as one carrier.~~

~~(h) Every solicitor or solicitor firm contracting with one or more carriers to solicit enrollments or subscriptions from responsible parties for children shall do all of the following:~~

~~(1) When providing information on contracts to a responsible party for a child or children but making no specific recommendations on particular health benefit plans:~~

~~(A) Advise the responsible party of the carrier's obligation to sell to any responsible party any health benefit plan it offers for children and provide them, upon request, with the actual rates that would be charged for that child for a given contract.~~

~~(B) Notify the responsible party that the solicitor or solicitor firm will procure rate and benefit information for the responsible party for the child on any health benefit plan offered by a carrier whose contract the solicitor sells.~~

~~(C) Notify the responsible party that upon request the solicitor or solicitor firm will provide the responsible party with the summary brochure required under this paragraph for any health benefit plan offered by a carrier with whom the solicitor or solicitor firm has contracted to solicit enrollments or subscriptions.~~

~~(2) When recommending a particular benefit plan design or designs, advise the responsible party that, upon request, the agent will provide the responsible party with the brochure required by paragraph (1) containing the benefit plan design or designs being recommended by the agent or broker.~~

~~(3) Prior to filing an application for a responsible party for a child for a particular contract:~~

~~(A) For each of the health benefit plans offered by the carrier whose contract the solicitor or solicitor firm is offering, provide the responsible party with the benefit summary required in paragraph (1) and the standard risk rates for that particular child.~~

~~(B) Notify the responsible party that, upon request, the solicitor or solicitor firm will provide the responsible party with an evidence of coverage brochure for each contract the carrier offers.~~

~~(C) Notify the responsible party for a child that, from January 1, 2011, to December 31, 2011, inclusive, actual rates may be 20 percent higher or lower than the standard risk rates, and from January 1, 2012, to December 31, 2013, inclusive, actual rates may be 10 percent higher or lower than the standard risk rates, depending on how the carrier assesses the risk of the child.~~

~~(D) Notify the responsible party that, upon request, the solicitor or solicitor firm will submit information to the carrier to ascertain the child's risk adjusted risk rate for any contract the carrier offers.~~

~~(E) Obtain a signed statement from the responsible party acknowledging that the responsible party has received the disclosures required by this section.~~

~~10963. (a) At least 30 business days prior to renewing or amending a health benefit plan subject to this chapter that will be in force on the operative date of this chapter, a carrier shall file a notice of material modification with the commissioner. The notice of material modification shall include a statement certifying that the carrier is in compliance with subdivision (i) of Section 10950 and Section 10960. The certified statement shall set forth the standard risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be renewed or amended. Any action by the commissioner to disapprove, suspend, or postpone the carrier's use of a health benefit plan shall be in writing, specifying the reasons that the health benefit plan is not in compliance with the requirements of this chapter.~~

~~(b) At least 30 business days prior to offering a health benefit plan subject to this chapter, all carriers shall file a notice of material modification with the commissioner. The notice of material modification shall include a statement certifying that the carrier is in compliance with subdivision (i) of Section 10950 and Section 10960. The certified statement shall set forth the standard risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be offered. Carriers that will be offering to a responsible party for a child contracts approved by the commissioner prior to the effective date of this chapter shall file a notice of material modification in accordance with this subdivision. Any action by the commissioner to disapprove, suspend, or postpone the carrier's use of a health benefit plan shall be in writing, specifying the reasons that the health benefit plan is not in compliance with the requirements of this chapter.~~

~~(c) Prior to making any changes in the risk categories, risk adjustment factors or standard risk rates filed with the commissioner pursuant to subdivision (a) or (b), the carrier shall file, as an amendment, a statement setting forth the changes and certifying that the carrier is in compliance with subdivision (i) of Section 10950 and Section 10960. A carrier may commence offering health benefit plans utilizing the changed risk categories~~

~~set forth in the certified statement on the 45th day from the date of the filing, or at an earlier time determined by the commissioner, unless the commissioner disapproves the amendment by written notice, stating the reasons therefor. If only the standard risk rate is being changed, and not the risk categories or risk adjustment factors, a carrier may commence offering health benefit plans utilizing the changed standard risk rate upon the 31st day after filing the certified statement unless the commissioner disapproves the amendment by written notice.~~

~~(d) Periodic changes to the standard risk rate that a carrier proposes to implement over the course of up to 12 consecutive months may be filed in conjunction with the certified statement filed under subdivision (a), (b), or (c).~~

~~(e) Each carrier shall maintain at its principal place of business all of the information required to be filed with the commissioner pursuant to this section.~~

~~(f) Each carrier shall make available to the commissioner, on request, the risk adjustment factor used in determining the rate for any particular child.~~

~~(g) Nothing in this section shall be construed to limit the commissioner's authority to enforce the rating practices set forth in this chapter.~~

~~10964. The commissioner may issue regulations that are necessary to carry out the purposes of this chapter. Prior to the public comment period required by regulations under the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the commissioner shall provide the Director of Managed Health Care with a copy of the proposed regulations. The director shall have 30 days to notify the commissioner in writing of any comments on the regulations. The director's comments shall be included in the public notice issued on the regulations. Any rules and regulations adopted pursuant to this chapter may be adopted as emergency regulations in accordance with the Administrative Procedure Act. Until December 31, 2015, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Any regulations adopted prior to December 31, 2015, in order to remain in effect after December 31, 2016, shall~~

~~be readopted as nonemergency regulations in accordance with the Administrative Procedure Act prior to December 31, 2016.~~

10959. (a) All health benefit plans offered to a child or on behalf of a child to a responsible party for a child shall conform to the requirements of Section 10127.18, 12682.1, and 10273.4, and shall be renewable at the option of the child or responsible party for a child on behalf of the child except as permitted to be canceled, rescinded or not renewed pursuant to Section 10273.4.

(b) Any carrier that ceases to offer for sale new individual health benefit plans pursuant to Section 10273.4 shall continue to be governed by this chapter with respect to business conducted under this chapter.

(c) Except as authorized under Section 10958, a carrier that as of the effective date of this chapter does not write new health benefit plans for children in this state or that after the effective date of this chapter ceases to write new health benefit plans for children in this state shall be prohibited from offering for sale new individual health benefit plans or in this state for a period of five years from the date of notice to the commissioner.

10960. On or before July 1, 2011, the commissioner may issue guidance to health plans regarding compliance with this chapter and such guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The guidance shall only be effective until the commissioner and the Director of the Department of Managed Health Care adopt joint regulations pursuant to the Administrative Procedure Act.

~~SEC. 3.~~

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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